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What the Adoption Worker
Should Know About Infertility

Referrals for Residential
Treatment

Social Science and Social Work:
Appraisal of Interdependence

Some Problems in Developing
Research on Adoption

Services to Unmarried Mothers

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HENRIETTA L. GORDON, Editor

CHILD WELFARE is a forum for discussion in print of child welfare problems and the programs and skills needed to solve them. Endorsement does not necessarily go with the printing of opinions expressed over a signature.

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WHAT THE ADOPTION WORKER SHOULD KNOW ABOUT INFERTILITY*

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The author suggests that the medical findings of infertility investigation play a fundamental role in every couple's application for adoption, and optimum requirements of an infertility study should be complied with, as outlined in his article, and integrated, through the use of proper consultants, into the entire adoption study.

IN THE SELECTION of adoptive families, agencies draw primarily from childless couples. Leading child-placing agencies require thorough medical exploration of infertility as precedent to an application to adopt a child. It is, therefore, essential that adoption workers understand what an adequate infertility work-up comprises.

Sterility and infertility are terms which are often used interchangeably. Reference to the dictionary, however, reveals that these terms cannot be so used. Sterile is defined as "incapable of producing." It describes a condition that is unalterable. Infertile is defined as "non-producing," a functional state, temporary or reversible. In other words, sterility is permanent, produced by absence or removal of the gonads or by the absence, removal or blocking of such organs as transport the sex cells or are necessary to provide growing space for the fertilized egg. It is an irreversible condition. Infertility is frequently temporary, often relative, and is curable, the outlook depending on the underlying causes.

The causes of infertility are so manifold that their discussion is best carried out together and along with the description of an adequate infertility examination. Methods of treatment will be discussed briefly, and finally some suggestions will be made for integration of the medical findings into the adoptive picture.

* Presented at CWLA National Conference on Adoption, January 1955, Chicago, Ill.

It has been said that "knowledge is but a small island in the vast sea of the unknown." As our knowledge grows, the shore lines of this island increase, that is, our contact with the unknown is ever increasing. This applies so well to our field under discussion. Tremendous strides have been made in the diagnosis, treatment and study of infertility, resulting in the fact that today a thorough infertility study should demand much more in the way of observation and specific examinations than we so frequently see being done. Relatively few years have passed since it was recognized that the male is responsible in from forty to fifty per cent of infertility cases. And it is only in recent years that the male has become gradually less resistant to an infertility investigation. This is an important step forward, because an infertility study must include a study of both partners in all details, and the heretofore casual semen examination of the male, resulting in his exoneration because a few motile sperm cells were visible under the microscope, has given way to a detailed study such as the female has undergone for many years already.

Medical History Reveals Disorders

A careful and thorough medical history of both partners will reveal absence or existence of systemic disease, such as diabetes, renal disease, thyroid disorder or nutritional aberrations which may shed light on the infertile state. Glandular disorders, expressed in menstrual irregularities, or in the male in arrest

of the sexual development may be of importance.

A general physical examination often leads to discovery of obvious causes of infertility. Undescended testicles in the male, arrested development of the female genital organs, generalized bodily signs of glandular disorders in either partner can in this way often be detected or at least suspected, and further study thus initiated. In other instances pathological conditions may be discovered that were without symptoms and, therefore, were unknown to the patient. Laboratory tests, including a test for syphilis, a basal metabolism, a complete blood count, and a urinalysis, round out the general examination needed by both partners.

From the outset, the gynecologist advises the couple who come for help because of childlessness that a thorough and careful infertility investigation cannot be done hurriedly. The cyclic nature of the female reproductive system demands that certain tests be carried out only once a month, and if they have to be repeated, another month or two may have to go by. The couple must know that certain observations have to be carried out and that a total work-up may easily take six months, during which time one of the partners or both may have to be seen by the doctor at three- to four-week intervals.

From this point on, the method of investigation varies for male and female, because the function of the respective reproductive glands is now in question. It is logical to begin with a semen examination, as it entails the least discomfort to the couple. As we progress to testing tubal patency, doing endometrial biopsies and other necessary tests, certain, however minimal, pain or potential danger may be encountered. This then is the reason why we usually advocate the semen examination as the first test. Certain precautionary measures are to be observed to obtain a reliable result. The specimen must never be collected or submitted in a condom which contains certain chemicals that frequently kill sperm cells. It should not be older than two to three hours, and should

be kept cool during this period. The observations must include:

1. the amount of the total specimen in ccm.,
2. the degree of viscosity,
3. the number of sperm cells per ccm.,
4. the percentage of motile cells,
5. the degree of motility expressed from one to four plus,
6. the percentage of abnormal sperm cells, and finally
7. the kind and amount of other cells present.

Only specimen that have undergone such detailed scrutiny are acceptable in an infertility study. It is not possible to give a lower limit for a sperm count below which an egg cannot be fertilized. As much or more depends on the motility and survival time as on the total number of sperm cells present. Not infrequently two or more semen specimen have to be examined before a favorable or unfavorable opinion can be given.

Test Tubal Patency

Many times a couple will present x-ray pictures as evidence that the woman's tubes are patent. She has been informed by her physician of this fact, visible on the films. The conclusions that her tubes are therefore normal for purposes of transporting the egg and the sperm are, however, fallacious. The functional patency of the Fallopian tubes can only be ascertained by the "Rubin" test, an office procedure, in which the passage of carbon dioxide gas through the Fallopian tubes is tested under conditions which permit the gynecologist:

1. to observe the pressure which is needed to drive carbon dioxide gas through the tubes,
2. to register the degree and amount of contractions of the muscular covering of the tubes during the test,
3. to take notice of the occurrence of immediate or delayed shoulder discomfort after the test.

At times it may be necessary to repeat the tubal patency test two or more times before a definite answer can be given. Tubal patency varies at different times of the menstrual cycle, and the best time must be chosen for performing the test. This is just before or at ovulation time when the tubal musculature is most relaxed and spasm least likely to occur. The x-ray visualization of the tubes should be reserved for cases where

patency cannot be demonstrated by the Rubin test and where we may gain more information as to where in the tubes the obstruction is located. The primary testing of tubal patency by means of injecting a radio-opaque medium into the tubes and taking x-rays is not acceptable as proof that the tubes are normal.

Observation of Ovulation

For many years the keeping of a basal body temperature (BBT) chart has been used to obtain an impression whether the woman under investigation is ovulating. The procedure is as follows: Each morning upon awakening the woman takes her temperature according to the directions given her, and she charts the result daily. This results in a curve which in a normal ovulating woman has two phases: a low one for about twelve to fourteen days after the menstrual period, followed by a rise at about the fourteenth day and a higher phase which persists until onset of the next menstrual period. The keeping of this BBT record under the supervision of the physician is very important as it gives the latter much valuable information. Such a chart should however, never be construed to be a timetable for the couple as to when the best time for conception is at hand during any given month. This emphatic statement is made for two reasons:

1. nobody—not even the expert—can interpret the BBT curve until the monthly cycle has been completed and the “timing” would be poor guesswork indeed,
2. by trying to follow a “timetable” the spontaneity of the sex life is badly shaken, and a psychological factor may possibly be added to the infertility problem at hand.

The temperature readings must be taken for a period of three to six months before the observing physician can draw any conclusions from them.

Another test to observe the presence of ovulation in a given cycle is the endometrial biopsy, carried out as an office procedure. In this test a small strip is removed from the lining of the uterus and examined under the microscope. The test must be carried out

close to the day when the menstrual flow is to begin, and the tissues obtained must be carefully prepared for the microscopic examination or the findings may be misinterpreted. It takes more than a good pathologist to interpret an endometrial biopsy as this interpretation has to be carried out in the framework of other findings in the individual patient.

Even though the sperm may be plentiful and normal in every respect, it may become inactive if the secretions of the female genital tract are inimical to it. We know that the secretions of the vagina are never favorable to the survival of sperm cells, but that the secretions of the cervix—the lower portion of the uterus—undergo cyclic changes which only at certain times of the month are favorable to sperm cells. The knowledge that the cervical glands produce secretions which favor survival and transport of sperm cells around the time of ovulation is utilized for the compatibility test. Within two hours after intercourse, secretions are removed from the cervix and examined under the microscope for the presence of motile sperm cells. If they are present, the test is favorable; if absent, and the test performed at the correct time of the cycle, this hostile environment for the sperm population has to be improved.

Treatment of the Couple

Proper treatment of the infertile couple begins at the first visit when the patients are advised what to expect from an infertility work-up, and how long it will take before a final answer can be given. The reasons for each test are outlined to them, and both husband and wife should leave the first interview knowing that there is no “miracle-drug” cure for them, that hormone shots or pills only rarely are indicated in the rational treatment of infertility, and that their chances to reach their goal are good until proven otherwise by the outcome of the tests. Reassurance should be the keynote at every visit and at every test. It is of importance to advise patients of the outcome of each test as it is performed. This should not be construed

in terms of jubilant unjustified enthusiasms when certain tests are favorable, nor as unnecessary pessimism, if certain tests should be below par. But the results should be explained in the light of the functional variations to which any test of a physiological nature is exposed.

Dietary deficiencies may need correction. A high protein diet with an increased vitamin intake is often advisable. Thyroid medication is indicated when the basal metabolism or clinical manifestations indicate lack of thyroid substance. Iron is prescribed if anemia is found during the blood examination. In short, all factors which are found to be below par are corrected, because a poor semen picture, or poor ovulation response, may well be due to a general debilitated state. In the male, chronic infection of the prostate gland may have to be eradicated. In the female, drugs to remove spasm of the tubal musculature are often found indicated and are helpful. Infection of the cervix must be treated by cautery or other appropriate means to improve the survival time of the sperm cells in the uterus.

The question frequently arises as to when a couple should consider undergoing an infertility investigation, and it is usually accepted that one year of married life without use of contraceptives should pass, before an infertility work-up should be started. Another question raised is how long a couple should remain under investigation or treatment? If a factor or factors are found that will make conception impossible, the couple should be so advised and the investigation terminated. There are definite limits to our therapeutic ability, and it must be clearly stated that the use of hormones to produce or increase sperm production is strictly experimental, and that no sound basis exists at this time for such treatment. The same pertains to any hormonal treatment of absence of ovulation. There is today no known hormone which will, in the human female, stimulate or produce ovulation. In our endeavor to find such agents, we conduct clinical research in the course of which patients are given hormones. They must understand, however,

that such treatment is entirely experimental and should be used only after all conventional means of treatment have failed.

If all tests are within the range of normal, the period of observation should extend over six to twelve months. During this time the above-mentioned steps toward improving the various factors are taken. At the end of that period, it is usually advisable to have a conference with the couple, explaining the satisfactory outcome of the study, and pointing out to them that another six to twelve months should pass without the possible anxieties involved in monthly observations and tests. If at the end of that period, now a total of three years, no pregnancy has occurred, plans for adoption should be discussed.

Psychological Reasons for Infertility

The term "functional infertility" is frequently used in lieu of a better term for a childless couple who have undergone all infertility tests and the entire period of observation without bringing to light any organic or physiological pathology. And still no pregnancy occurs. It is in such couples especially, that we look for psychological reasons of the infertility. The field of the psychological influence on infertility is practically untouched. Even though almost everybody knows some couple who achieved a pregnancy after adopting a baby and tries to make the adoption responsible for the "relief of tension" which caused the pregnancy, the work of Rock and others puts these experiences strictly in the category of "chance." There is no question that many an infertile couple has psychological difficulties; it can also hardly be denied that undergoing an infertility study over a prolonged period of time and wanting a child desperately, can scarcely prevent the average couple from becoming anxious. The real connection between physiological processes like ovulation and emotions has not been solved, and it is hardly within the framework of this discussion to dwell on it further.

It may now be appropriate to make some suggestions to integrate the medical findings

into the adoption investigation. If sterility, as defined in this presentation, is known in a couple applying for adoption, no further medical investigation is necessary, over and above the criteria of general physical and mental health which have always been required in any adoption study. If infertility factors are presented as the basis of the adoption request, it seems logical that a strict yardstick must be applied to the evaluation of the results as they are presented to the agency. A detailed medical questionnaire should be returned by every applying couple. The information should include all the points raised in this discussion. Agencies would do well to have on their staff a consultant gynecologist, who is an

interested expert in infertility. The adoption worker should have occasion to discuss the infertility picture of every applicant with this consultant. It seems furthermore feasible that every adoption agency should have on hand a referral list of gynecologists who are interested in infertility and willing to cooperate with the agency to obtain or to complement the necessary study, so that couples are not deprived of the possibility of natural parenthood because they have been unable on their own to find a competent infertility expert. This is not to be construed as a devaluation of the practicing physician, but only as expression of the ever-increasing amount of specialized work needed in an infertility study.

REFERRALS FOR RESIDENTIAL TREATMENT

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Sister Serena, M.S.W.

Administrator
Astor Home for Children

The authors discuss the kinds of children who have been referred to this treatment center and the problems involved in deciding the variety of types which one institution may be able to serve.

THIS IS ONE of a projected series of studies dealing with the many aspects of residential treatment of the emotionally disturbed and mentally ill child. Since the forms of residential treatment are varied, these studies will in large part reflect the particular emphasis of the Astor Home, but always utilize the valuable insights which have come from other studies. Because of the tentative nature of many of the criteria, for selection of patients, for types of treatment, for length of residence, and many others, and since those of the Astor Home will be continually modified, we feel that it is important that the professionals in other branches of child welfare and treatment be informed of current practices; for the community is now concerned with the question of how to best use these specialized facilities. While subsequent papers will present in more detail the functioning of the treatment center and the view-

points of the residential workers, this paper, dealing with type of cases referred to the Astor Home, seems to mirror what those working in clinics, courts, and schools see at present in the treatment center and what they expect it to accomplish.

The Astor Home for Children is located in Rhinebeck, N. Y., an historic town in the Hudson River Valley approximately one hundred miles from midtown New York City. The building is a durable three-story English Tudor structure; the fourteen acres of grounds, enhanced by streams and woodlands, have adequate recreation fields. The center has attractive living quarters, school and treatment facilities. At the time of this writing there are in residence twenty-seven boys, aged six to twelve, and an additional wing is being constructed which will enable the center to accommodate thirty-five boys. It is one of the three pilot projects initiated by the New York State Mental Hygiene Commission, and it is administered by the Daughters of Charity, an order of Catholic nuns, under the supervision of the Catholic Charities of the Archdiocese of New York. The full-time staff includes nuns who are trained in administration, psychiatric nursing, social

work, special education; the lay staff comprises a psychiatrist who is the medical director, therapists representing the fields of psychology, psychiatric social work, and occupational therapy, and persons who function as recreation counselors under the direction of a social group worker. It is part of the special education system of the New York City Board of Education, and known as P.S. 617. All children are seen three to four hours a week in individual psychotherapy. The living arrangements are the direct responsibility of psychiatric nurses.

The Initial Referrals

The Astor Home received its first patients in January 1953, and this report is concerned with the first two hundred referrals over a period of approximately twenty-two months. All referrals have been through public agencies—the courts, guidance clinics, hospitals, and schools. The referral material here considered is the complete, or relatively complete case report, including psychiatric and psychological examinations, and we have excluded the many less formal sources of referral such as telephone calls and letters of inquiry. Initially patients were placed on the waiting list and accepted solely on the basis of the referral material, but in the past six months patients are placed on a waiting list only if a psychiatric examination at the Astor Home reveals that they will fit in with the treatment program. The material deals only with the diagnostic classifications and the degree of severity of the illness and the relation of these two factors to the fulfillment of the function of the residential treatment center, that of treatment of emotional illness. Of the first two hundred referrals for residential care the breakdown in diagnoses is:

Table No. I

Schizophrenia	34
Chronic Brain Disorders	14
Mental Deficiency	28
Epilepsy (Petit Mal)	1
Adjustment Reaction of Childhood	20
Psychoneurosis	16
Primary Behavior Disorder	61
Psychopathic Personality	7
None Given	19
	200

For purposes of further discussion we have classified the children referred on a basis of "aggressive" and "aggression-inhibited" symptomatology: one hundred and thirty-two presented aggressive symptomatology;

Table No. II

Aggressive Children	
Primary Behavior Disorder	56
Schizophrenic	24
Mental Deficiency	16
Adjustment Reaction of Childhood	16
Chronic Brain Disorder	9
"Psychopathic Personality"	7
No Diagnosis Given	4

and there were twenty-nine showing inhibition of aggression.

Aggression-Inhibited Children	
Schizophrenia	9
Psychoneurosis	8
Mental Deficiency	4
Adjustment Reaction of Childhood	4
Petit Mal Epilepsy	1
No Diagnosis Given	3

In thirty-nine cases the referral material was such that we were unable to classify the children on this basis.

This referral material is characterized by a much greater proportion of the acting-out, aggressive child, either of the psychotic variety or of the various forms of neuroses and character disorders, and a relative absence of the aggression-inhibited child typified by the depressed, phobic, obsessive and compulsive and autistic children. The most obvious reason for this, and one of the principal reasons that the State Mental Hygiene Commission sponsored these projects, is that the aggressive child presents the emergency situation and is a pressing social problem. In many cases he has been excluded from school, in very many cases the parents are unwilling or unable to handle him at home. He is too disturbed to be helped in the normal child-caring institutions, many of which handle

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one hundred to five hundred children, and the limitations of the children's psychiatric services of the general hospital are usually such that he can remain only for a short time for observation and diagnosis. The referring agency has felt that the prognosis is favorable and custodial care is considered only as a last resort. The residential treatment center, with its small patient load, large and well trained staff, therapeutic environment, close supervision, and intensive psychotherapy appears to the community agency to be the ideal solution to the problem.

The Aggression-Inhibited Child

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The aggression-inhibited child is not often an emergency community problem. It is interesting that there have been few inquiries about the date of admission for the few of these children whom we have had on our waiting list; there have been many reminders of the urgent need for admission of the aggressive children. The children whom we have called aggression-inhibited have difficulty in relating, or are withdrawn, or overconforming. Some manifest a serious delay in the essentials of habit training and sociability so that they are often spoken of as retarded or infantile. Many are able to carry on quite adequately in the school, and those who are not able to participate in the learning process are not noticed in large classes and are passed on from grade to grade, or are easily cared for in the slow learners' classes. Unless they are suicidal, a rarity in children, they are usually able to be cared for in the home, or if the home has been broken they are readily accepted into the normal child-caring institution.

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It would seem to many (referring agencies and others) that the residential treatment center is the place for the acting-out child whose behavior has not been sufficiently deviant for him to be sent to a training school. It may be that from long experience they know that many such children will not do well in the other facilities and that the treatment center is best constituted to effect improvement, or that this is the most expeditious means of handling the vexing

problem. This has been expressed by Jenkins and Hewitt:

"... older children and adolescents who are of the unsocialized, aggressive make-up usually cannot be effectively treated outside of an institution, because adequate control is impossible in the open democratically organized community" (6).

It is interesting to find that the pioneers of child care in other fields have been concerned with just this problem. In writing of the first schools for the mental defectives Goodenough says:

"Then as now, the number of applicants vastly outnumbered the places available within the schools, and community pressure was greatest in those cases where misconduct as well as mental defect made the child an unwelcome member of society. It thus became necessary for those in charge of admissions to be constantly on their guard in order to avoid turning their schools into mere reformatories for delinquents" (5).

It is remarked by Levy and also by Lowrey that the beginners in the child guidance movement were concerned lest the clinics be thought of as places for treatment of only children with socially disturbing behavior (9, 10).

It may well be that the residential treatment center is most able to treat rather than merely contain the aggressive and delinquent child. There has really not been enough time to know whether this will be the case with the Astor Home. But aside from the reasons of emergency nature which have been mentioned, there is the question of why the aggression-inhibited child is not more often referred. Is it because of the difficulty of diagnosis, because of the relative infrequency of this type of child, or because he is adequately handled in other facilities?

What Other Authorities Say

A search of the literature gives us but partial answers to these problems. Kanner states that children are rarely brought to psychiatric attention with the complaint of obsessive tendencies before the fourteenth year (7). Bender has shown an incidence of obsessive-compulsive phenomena of approximately 2.2 per cent in a series of 2800 cases of four years (1). The problem of anorexia nervosa and often of compulsive eating has its great-

est incidence in adolescent girls. There have been few reports on depressions in childhood, although McHarg has recently written on manic depressive psychosis in childhood and has extensively reviewed the literature on this controversial subject (11). Robinson and Vitale have reported a small series of "Children with Circumscribed Behavior Patterns" between the ages of eight and eleven treated in a residential center (15). There have been several reports of phobic children and children with school phobias, treated in private practice and in guidance clinics. In the twelve residential centers described by Reid and Hagan it appears that most of the patients are aggressive and acting-out children, although a very small percentage of compulsive, autistic, phobic and depressed children are in residence (13).

In terms of long term studies we have little in the way of follow-up of children treated in private practice, guidance clinics or treatment centers. Morris, et al., have reported on long term follow-up of fifty-four shy, withdrawn children, one to sixteen years of age at time of referral to a guidance clinic, and report that only two could be classed as "emotionally sick" (12). However, the report gives very little indication of the severity of the pathology. The Jewish Board of Guardians Clinic, Hawthorne-Cedar Knolls, and the Ryther Child Center have made a worthwhile start here (2, 8, 14). The answer may be that there are relatively few cases of the withdrawn or phobic or compulsive varieties or it may be that they are handled well in the school and guidance clinics. Lehrman's group reported that the "psycho-neurotic" children showed less improvement in the guidance clinic than the "primary behavior disorders" (8). Rogers made this interesting observation:

"The community or state with sufficient social vision to establish and support a progressive institution also maintains other service for problem children. As a consequence, more children are dealt with in the community, a smaller proportion are sent to institutions, and this group contains a higher ratio of very unstable and more difficult children. Hence it is a common experience of institutions to receive their most hopeless youngsters from the communities with the best educational and child welfare facilities" (16).

Prognosis

We wonder in terms of prognosis, if the aggressive child is necessarily more disturbed and ill than the withdrawn and aggression-inhibited. Those who have extensively studied the problem of juvenile delinquency do not seem to hold to this view. Bovet has pointed out the relation of psychoneurosis to delinquency in that compulsives are capable of committing crimes of physical and sexual aggression, of setting fires; that at some point the numerous suppressions and repressions of the neurotic which protect him from his anti-social impulses may break down (3). Bender warns that many children with compulsive behavior will eventually show "impulsive" behavior (1). There have been some retrospective studies, notably that of the Gluecks (4) showing that delinquents of the adolescent period were showing signs of maladjustment many years before they came to the courts, and there was a most interesting study by Kasanin in 1932 showing that approximately one-half of the adult State Hospital patients in a small series (54 patients) were "aggression-inhibited" as children. The Gluecks point out that: "From a clinical and prognostic point of view, other forms of maladjustment might be more serious than those types of behavior which the law prohibits."

If it is true that the residential treatment center offers a setting conducive to improvement of the behavior disorders, there arises the question whether the preponderance of aggressive children in a center noticeably reduces the benefits of residential care. Ultimately only long experience will answer this, but our brief experience has raised some questions on this score. When the patient population is heavily weighted on the side of the acting-out child, the environment may be too stimulating and tense for the individual child, and often potentially or actually explosive. The aggressive child certainly needs a measure of control and an attitude of total permissiveness is hurtful to him. When there are too many aggressive children the control may need to be too constant and too comprehensive. This can lead only to further

need for aggression and could result in the complete breakdown of control. It is not at all reassuring to a child to see a staff struggling from moment to moment to keep at least some limits of control.

Patient "Balance" Important

While it may be well to think of patient "balance" in terms of age, sex, and race, balance in terms of the aggressive and the aggression-inhibited children seems quite important. It may be that when there is this "balance" there is more movement of patients. While the withdrawn schizophrenic and the compulsive child respond quite slowly, it appears that many depressed and phobic children may be more quickly helped. The stimulus of seeing others get well relatively quickly, of seeing them return to their families or to foster homes is therapeutic. The departure of a friend may help a hostile and belligerent boy move into treatment. It would seem that a better balance makes for a more efficient and satisfied staff, and ultimately the confidence and enthusiasm of the staff contribute to the gains of the children. With a preponderance of aggressive children the staff may need to be too controlling, tend to rely too exclusively on the techniques of isolation, restriction, and reduction of stimuli. There is less opportunity to use the many techniques and skills of stimulating the inhibited child. These are indeed important sources of gratification to the staff; to stimulate the depressed and withdrawn children, to work with many types of symptom formation. If the therapist treats only the aggressive child he may easily fall into a routine of attempting only to control or suppress. Or he may tend to over-stimulate the child, and create further problems of control for the child and the staff. There are some indications in our experience that a very great part of the improvement in these aggressive children comes from environment of the center, and it is often difficult to see the relation of improvement to anything in therapy other than the positive relationship to the therapist. The therapist may need to be content with such minute and slow gains

that his feeling for the prognosis may become distorted due to his identification with the patient.

The question has been raised of centers for particular types of problems, for example, the psychotic child, but is it necessary or desirable to make this specialized treatment facility even more specialized? Ultimately the ability of a particular facility to treat any given case will depend upon a number of factors including the location, the physical structure and the skills of the staff.

Since this is but a beginning we do not claim to have the answers to these complex problems, but we do wish to acquaint those outside the residential treatment center with the problems. It should also be noted that the establishment of residential treatment centers has not materially altered the prognosis of many types of illness, most notably the schizophrenias and the group we call "affectless" or "empty" or "psychopathic." Because of the great expense of residential treatment and of the limited number of placements in residential treatment that can be offered to those who will gain by it, it is most important that a center whose primary function is service does not undertake the treatment of many children whose ultimate outlook is most unfavorable. This is another reason, among many others, for stressing the importance of accurate diagnosis both in the etiological and dynamic sense. However, such a facility is well suited to carry on intensive research, and by this research we may gain understanding of these cases which now have an unfavorable prognosis.

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CURRICULUM STUDY

The Curriculum Study on Social Work Education, announced by the Council on Social Work Education, is under way. The Study has undertaken to examine selected issues in three areas: social work methods,

including field work practice; human growth and behavior; and the social services. Particular attention will be paid to the public social services and rehabilitation. The Study will attempt to answer some selected questions, among which are:

1. What is the appropriate distribution of the social work curriculum on the graduate and undergraduate levels?
2. What is the desirable social science content of social work education?
3. How can better integration be achieved among and within the several sequences in the social work curriculum?
4. What is the place of social policy in the social work curriculum?
5. What are the ingredients of generic and specific education in social work?

The overall assumption which at present governs the thinking of the Study staff is that the tasks executed by social workers may be distributed through a continuum and may be classified according to categories in which not only common knowledges and skills may be identified, but also different levels of knowledge and skill. The findings of the Study should lead to a structuring of curriculum content on both the undergraduate and graduate levels of social work education.

The data for the Study will be drawn from sample studies of practitioner groups, analyses of the practice of social work, educational materials available from the schools and departments, materials contained in the literature and files of the CSWE and pertinent materials secured from other professions.

The Study Committee is earnestly concerned to have the cooperation of schools and departments. In order to be able to take into account the on-going concerns of the graduate schools of social work and the undergraduate departments, the Study staff urges that all materials relating to curriculum activities such as committee reports, statements of objectives, course outlines and syllabi, etc., be made available to them. These materials should be sent to Werner W. Boehm, Council on Social Work Education, 345 E. 46th St., New York 17, N. Y. The Study Committee hopes that late in 1957 it will be ready to have schools and departments test the findings.

The Study is being financed by The Field Foundation, Rockefeller Brothers Fund, Ittleson Family Foundation, National Tuberculosis Association, National Institute of Mental Health, and Office of Vocational Rehabilitation.

SOCIAL SCIENCE AND SOCIAL WORK: AN APPRAISAL OF INTERDEPENDENCE*

Martin Wolins

Director of Research
Child Welfare League of America

Social work and the social sciences are now at the beginnings of a new awareness—an awareness of each other's existence, usefulness, needs and potentials. The practice—social work—seeks new knowledge and new tools which may improve its services. The sciences—sociology, psychology, cultural anthropology—seek new ways of gathering knowledge and of having it applied to the benefit of man. That they are finding

one another to establish or renew relationships promises well for both the sciences and the practice.

The Child Welfare League, in line with its interests in developing new knowledge and improved practice relative to child welfare, wishes to emphasize the importance of the science-practice relationship. The following paper is an evaluation of this relationship. Other papers bearing the fruit of social science-social work collaboration will be presented in the future.

MUCH IS OCCURRING these days both in social work and the social sciences that may be considered in the nature of bridge building between them. It is proper to use the term bridge building and not bridge crossing, since there still exists between these sciences and the practice of social work a considerable unbridged gulf. To understand the nature of the new relationship of social science and social practice, it may be helpful to discuss the nature of the desired bridge and of the two shores—the science and the practice.

For the purposes of this paper, only one behavioral science—sociology—will be discussed, and only one form of social work practice—casework.

The gulf between social work and sociology, which during the past several decades had been broad indeed and only recently has narrowed, might never have developed. That it developed is perhaps attributable to the immaturity of both the practice and the science and, conversely, the recently renewed collaboration is perhaps a sign of mutual recognition of maturity.

Historical View

Historians of social work and sociology in the United States most generally go back to

* This paper is based, in part, on a discussion by the author of several papers on sociology and social welfare. The paper was presented before the American Sociological Society on September 2, 1955.

what appears to be the common demonstrable beginning of both—the founding in 1865 of the American Social Science Association. The Association, a result of theoretical developments in positivistic philosophy and practical consequences of industrialization, was able to hold for only a brief period the seemingly divergent interests of these two forces. Soon, the purism of the theorists exceeded the frustration tolerance of the practitioners and reformers, while at the same time the practitioner's inevitable preoccupation with practice minutiae tended to hinder adequate theoretical development. It was thus that the practice-minded split off into the National Conference of Charities and Corrections, predecessor of the National Conference of Social Work of this day, leaving the American Social Science Association to continue as a scientific society and to spawn, by 1905, through several transformations, what is at present the American Sociological Society.

Although eventually the divergent interests of science and practice led to the division within the American Social Science Association and to the withdrawal of the practice-oriented, the differentiation between sociology and social work was not at the outset very marked. With time the gulf widened and survived numerous attempts at bridging. Notable among these bridging efforts were the sections on sociology and social work held

within the annual meetings of the American Sociological Society in the late 1920's; the MacIver book on the relationship of sociology and social work¹; and the numerous works of Mary Richmond², the latter injecting many sociological variables of family, group, community, into the practice of social work. In Richmond's writings we find, in fact, repeated and insistent demands upon sociology for usable data and along with these demands a suggestion that social work may well serve in helping obtain such data.³

Shortly after these events, social work in its search for an adequate theory of practice turned from the first predominantly economic formulations and the second mainly sociological formulations to a third area of emphasis—the psychiatric or more precisely, psychoanalytic. Some foreshadowing of these developments may be seen much earlier. In 1920, for example, Mary Richmond, after acknowledging the earlier domination of economists and social work's early satisfaction with broad generalizations, suggests that it is high time for “. . . seeking to find the special qualities of the individual unit. . . .”⁴

Strong emphasis upon the special qualities of the individual unit in the following three

¹ Robert M. MacIver, *The Contribution of Sociology to Social Work*, Columbia University Press, New York, 1931.

² Mary E. Richmond, *Social Diagnosis*, Russell Sage Foundation, New York, 1917; *What is Social Casework?*, Russell Sage Foundation, New York, 1922; *The Long View, Papers and Addresses*, Joanna C. Colcord and Ruth Z. S. Mann, eds., Russell Sage Foundation, New York, 1930.

³ In Richmond's book *What is Social Casework?*, p. 226, we find expressed her dissatisfaction with available sociological data and her stress upon the value of casework as a medium for obtaining a body of data on the family. In examining texts in sociology she says she has found in each at least one chapter on the family, but “. . . each handled the subject with polite caution and an absence of first hand observation which was depressing. The lack of substance in this initial portion of the subject matter of sociology is due not so much to timidity in the authorities as to the almost total absence of case studies which bear upon family life . . . Casework can develop a fruitful method of approach . . .” to the study of the family.

⁴ *The Long View*, p. 484.

decades led social work to its amazing dependence upon psychiatry and its equally amazing disregard of many “broad generalizations” produced by the social sciences. Thus, with the emergent professionalization of social work and the inevitable emphasis upon what social workers call the “casework basis,” i.e. the stress upon the individual rather than categorical qualities of a case situation, there also occurred a considerable disregard or abandonment of social science theory. In the rush toward individual diagnosis in the psychoanalytic framework, social work nearly lost its ability for “social diagnosis” in the sociological and economic framework. With the arrival of Freud and Rank in the front parlor, Richmond was relegated to the servants' quarters, and social science to the back yard. And much of this occurred in the name of professional development!

Relation of Social Work to Social Science

What, exactly, is the professional status of social work and what relation does it bear to social science? Greenwood points out that social work belongs in the genus technology and the specie practice. As such it aims to “. . . achieve controlled changes in natural relationships (of human beings) via relatively standardized procedures that are scientifically based.”⁵ This provides the first attribute which distinguishes the practice from science. Science is value free while practice is value laden.

The second distinguishing characteristic is the degree of empiricism. James B. Conant⁶ suggests the possibility of viewing the practices and science in terms of the degree of empiricism that may be found in each. Science, he indicates, is theoretical. The more theoretical a science, the more highly conceptualized its system, the better it is. Practice, on the other hand, is highly empirical. While science cannot build upon percepts

⁵ Ernest Greenwood, “Social Science and Social Work: A Theory of Their Relationship,” *Social Science Review*, XXIX, March, 1955, p. 24.

⁶ James B. Conant, *Science and Common Sense*, Yale University Press, New Haven, 1951.

until their conceptual position within a theory is clarified, practice, in the professions and elsewhere, can do so and is often compelled to do so.

While the above two distinguishing characteristics permit the separation of practice and science, they also point to their mutual dependence. Science is value free but its creations are potentially value forming. Also, the values of the practices do affect the direction of scientists if perhaps not science itself.⁷ Science is theoretical but it may fruitfully incorporate empirical observations and may also use the practice setting as a testing ground for its conceptually derived hypotheses.

Considered in terms of its values, social work is not markedly distinguishable from the other healing-preventing practices. The primary value of social work as expressed by Bisno is to help mend or prevent the breakdown of individual need-satisfying relationships, and to do so within culturally acceptable patterns in order to maintain or restore the well-being of the individual or the group.⁸ In terms of its degree of empiricism, however, social work still differs markedly from such healing-preventing practices as medicine and dentistry. On the common sense—science continuum, social work is closer to the common sense position than either of the above.

The "Practice Theory" of Social Work

What has happened in this aspect of social work development is that, under pressures to render service, social work has been unable to wait for the development of scientific knowledge or the translation and assimilation of existing knowledge and has based its actions on intra-professional empirical generalizations. As Dean Swithun Bowers has indicated, social work had outrun its corre-

sponding science.⁹ The basing of practice on the best at-hand knowledge is both understandable and defensible but it has not been comforting.¹⁰

While social work was developing a "theory" or "theories" of practice during the first three decades of this century, the theory has never been sufficiently broad nor cohesive enough to permit adequate practice deductions. Needed was a broad theory of motivation and behavior with built-in appli-

⁹ Swithun Bowers, O.M.I. "The Nature and Definition of Social Casework" in Cora Kasius (ed.) *Principles and Techniques in Social Casework*, FSAA, New York, 1950.

¹⁰ Isaac L. Hoffman, in a very enlightening paper *Toward a Logic For Social Work Research* (Amherst Wilder Foundation, May, 1952, Mimeograph), puts the argument thus, "As a professional art, social work practice . . . exists for the purpose of giving service. The needs of those who receive social work services are the compelling force which motivate and justify the services which are offered. So long as action is needed, action will be taken, whether or not the body of knowledge behind the service is sufficient for that action." p. 23.

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⁷ The position of values in science, especially social science, is not out of the realm of controversy. See George A. Lundberg, *Can Science Save Us?*, Longmans, Green and Co., New York, 1947, and George Simpson, *Science As Morality*, The Humanist Press, Yellow Springs, Ohio, 1953.

⁸ Herbert Bisno, *The Philosophy of Social Work*, Public Affairs Press, Washington, D. C., 1952.

cation to specific practice situations. In seeking to fulfill this need, social work has done exactly what Professor Robert Angell says it has: namely, it "... has absorbed that theory which has been most applicable to casework practice, that is social psychiatry ... [combining] psychiatric insights with empirical wisdom gained from practice."¹¹ The result, which is a mixture of practice wisdom with either Freudian or Rankian psychiatry, has been by far the dominant force in social work since the 1930's.¹²

The development and use of a practice-theory, a theory of the situation, though satisfactory in some respects, has fallen far short of meeting all the requirements of social work. First, case situations continually require the infusion of economic, sociological, psychological, anthropological and other knowledge beside psychiatry in order to deal adequately with problems of clientele. Second, psychiatry has not been able to provide for itself or to offer social work adequate

¹¹ Robert C. Angell, "A Research Basis for Welfare Practice" in *The Social Welfare Forum 1954*, Columbia University Press, New York, 1954, pp. 9-10.

¹² The importance of this relationship of social work to psychiatric theory may be noted in the fact that the primary controversy in social work since 1930 has been over functional vs. diagnostic casework, i.e. casework practice based on the will psychology of Otto Rank vs. practice based on the psychology of Sigmund Freud. A very significant aspect of this relationship has been the middle-man role of the consulting psychiatrist upon whom social work has often put the burden of adapting social science theory to social work practice needs. Since the psychiatrist's orientation was understandably psychiatric, his failure to translate, to adapt other social science material to the needs of social work is highly probable. What is more, this single avenue between social work and social science has, in most instances, become a one-way street. There has not been much flow of practice-derived observation from social work to social science where it might be used in theoretical formulation. See *A Comparison of Diagnostic and Functional Casework Concepts*, FSAA, New York, 1950.

See also Herbert Aptekar, *The Dynamics of Casework and Counseling*, The Riverside Press, Cambridge, Mass., 1955. This author, while speaking of the diagnostic vs. functional schism as "all absorbing," also notes that "... this conflict is playing itself out and that both schools of casework philosophy are ready for further growth and development." p. XI.

defenses against skeptics. I have in mind two specific kinds of skepticism that are constantly aimed at social work. The first generally emanates from scientists. In viewing what social work calls established theory they say, in effect: "Is that so?" The second kind of skepticism is generated by the lay public which says in regard to social work claims of achievement: "So what?" Neither of the above questions is stated as critically as it is here but both will require the use of social science theory and procedure in the refuting replies.

The New Emphasis on Social Science

Recognition of the problems inherent in social work's isolation from behavioral science has brought the profession to a point where some writers in social work claim with Stein that it is now "... in a position to assimilate, without great commotion, the research findings and new insights that emerge from the behavioral sciences."¹³ Some would not be as optimistic as Stein regarding the amount of commotion, but there is definitely a trend toward acceptance of social science theory in social work. This is, however, a recent development which is being brought about not only by growth in social work but also by advances in the social sciences. The latter are specifically these:

- (a) sufficient theoretical development permitting adequate generalization and interrelation of concepts;
- (b) adequate status allowing occasional preoccupation with practical aspects of scientific knowledge without fear of loss of the designation "scientist"; and (c) directly related to the above, the development of practice principles out of scientific theory by scientists who intermittently function in pure and applied science roles.

The developments in both the behavioral sciences and the behavioral practices have led to the following recognition by the Russell Sage Foundation in 1948: "The Foundation is now convinced that added emphasis should be given to the increasing body of

¹³ Herman D. Stein, "Social Science in Social Work Practice and Education," *Social Casework*, XXXVI, April, 1955, p. 147.

knowledge of human behavior to the end that practitioners in human affairs may have the most reliable basis possible for their work."¹⁴

Criteria of Productive Relationship

In considering the relation of behavioral sciences to social work in order to produce the "most reliable basis possible" for professional practice we may ask the following questions:

1. What should be the nature of knowledge transmitted to social work?
2. What should be the process of its transmittal from the behavioral sciences?
3. What can be useful in social work, what can it presently assimilate and put to practice use?
4. What can the behavioral sciences derive from their relationship with social work?

First, as to the nature of knowledge to be transmitted, there is probably no need for any distinction between the knowledge of science and scientific knowledge potentially useful in the practices. Science will be the more useful to practice the better science it is. And it will be better, the broader its generalizations, the more closely reasoned are the consequences of such generalizations and the better controlled are the tests of the consequences or, as the latter will be called in the experimental situation, the hypotheses.

Second, in the process of transmittal to social work practice, behavioral science must undergo an adaptation process which applies the concepts of the science to practice needs, i.e. theory must be converted to principles of action in order for it to be useful in the practice.¹⁵

Third, social work at this point stands fairly ready or will soon be ready to experiment in practice with any principles of action derived from the behavioral sciences wherever such principles lead in the direction of

the goals social work values. There is a beginning of understanding in social work that the "special qualities of the individual unit" become meaningful only within their class of phenomena—that "... there can be no meaningful uniqueness or individuality without the referential benchmark of generality."¹⁶ Such understanding will open social work to the use of relevant social science data as well as social science concepts.

Fourth, it is imperative that communication between the behavioral sciences and social work flows both ways. Social work practice can be a treasure house of methods, professional insights, "practice wisdom," descriptive data, and situations applicable to the testing of social science theories. As long as these remain unincorporated into broad theoretical schemes of science their usefulness to the professions is short of their potential and their value to science is nil.

Conclusion

In the awareness of each other, in the renewed collaboration between the social sciences and the practice of social work, effort needs evaluation in terms of the above criteria. It should be anticipated that the thoughtful practitioner, in his eagerness for relevant immediate solutions, will not pressure the scientist to abandon his science. It should also be anticipated that the wise scientist will make maximal use not only of his science but also of the practitioner's store of insights and situational wisdom.

From the practitioner, then, we should expect full use of available knowledge whether it be placed in the wisdom of his practice or in the theory of a related science. From the scientist we should hope to obtain conversion of his science to practice use, but in that we should guard against the possible misunderstanding that such conversion is never more than simplification. On the contrary, we should hope that social science will help refute the notion that adaptation of science to practice use is solely a matter of simplifi-

¹⁴ Russell Sage Foundation, Annual Report, 1947-48, p. 13.

¹⁵ In this connection it will be most helpful to have more sociologists, anthropologists, and other behavioral scientists assume consultants' positions in social work agencies along with psychiatrists.

¹⁶ Hoffman, *op. cit.*, p. 24.

cation and explanation of concepts. While social work is constantly in need of technical instruments and adapted conceptual insights of social science, its major need, as pointed out earlier, is for a broad theory of motivation and behavior, with built-in application to specific practice situations. These characteristics of the "practice theory" of Freud and Rank have so strongly appealed to social work that for decades little or no other influences were perceptible. Social science, for greater contribution to practice, as well as for its own development, must continually strive for higher-order theoretical integration. Such integration should lead in the direction of allowing social work to view each individual, each group, each community, not as a composite of independent parts but as a dynamic, interacting, interrelated whole. Ultimately, it should permit the social worker to approach closer to the total situation, as he could not do while employing fragments of social science knowledge.

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SOME PROBLEMS IN DEVELOPING RESEARCH ON ADOPTION

Donald Brieland, Ph.D.

Director

Elizabeth McCormick Memorial Fund
Chicago, Ill.

The author indicates certain assumptions important to the conduct of research on adoption, some of the important obstacles and suggests approaches to gathering data.

THE National Conference on Adoption held in Chicago in January 1955, highlighted two general conclusions:

1. the need for research on many aspects of the adoption process;
2. recognition of the scientific knowledge already available relating to adoption, which should and does affect social agency practice. It is easy to place emphasis on the second of these elements and to forget the first in the press of day-to-day responsibilities to get a practical job done.

Before the proceedings of the Conference are published, some of the problems involved in the development of adoption research can profitably be reviewed. Several assumptions underlying adoption have a bearing on possible research. The first of these concerns the acceptability of the adoption process—to society, to the child, the adoptive parents, and the natural parents.

Positive Attitudes of Society

Adoption is acceptable to society. Society considers adoption as an adequate means to provide for the rearing of children who must for some reason be deprived of growing up in a natural family. Adoption for a child is considered generally preferable to his living in an institution, and usually superior to placement in a foster home where there is no legal transfer of parental responsibilities to those persons who serve in fact as the child's parents.

Being adopted is acceptable. Children find relationships with adoptive parents rather like those of natural parents, with most of the same rewards and demands. The adopted child does not usually consider himself as being different from children who live with their natural parents, although he may have

special concerns from time to time about his identity and parentage. Society tries to give full legal rights to adopted children and attaches no social stigma to being adopted.

Being adoptive parents is acceptable. Childlessness may result in varying degrees of concern ranging from little if any disappointment or anxiety to deep feelings of personal inadequacy. Having no children by choice is likely to result in criticism. Inability to have them but applying to adopt them is an active step toward having a family. Adoption offers an opportunity not only to satisfy the needs of a child, but to satisfy the need for a child. More than that, adopting a child indicates to the outside world that childlessness was not intentional.

The relinquishing of a child for adoption by the natural parents is acceptable. Under certain circumstances this serves the best interests not only of the child but also of the natural parents and of society.

These positive attitudes of society and of the persons directly concerned in adoption should facilitate the conduct of research.

A second assumption to consider is: Most adoptive parents are willing to participate in research on adoption following the completion of the period of supervision as well as during that period, particularly when they understand that the purpose of research is to improve adoption procedures in the future, and not to alter or extend agency supervision for them.

Traditionally, the reluctance of the agency to make any subsequent contact with the family has been a barrier to research and may have resulted from an unrealistic sensitivity on the parents' part. Limited efforts to request information from adoptive parents have met with good success and the interest

of the agency has often been welcomed. Obviously, a program involving intensive contact that might be interpreted as continued supervision or just plain interference must be avoided. However, intelligently planned follow-up research will underscore the need to learn as much as possible about making adoptions successful rather than to suggest a desire to give advice or extended supervision. There is little reason to believe that research would be difficult to carry out because of strong parental resistance, if it is conducted with the usual emphasis on keeping individual case material confidential. The importance of the problems makes it necessary to go ahead with research, even though a certain amount of parental non-cooperation will be encountered. The success of research with clients in marriage counseling and psychotherapy, where one would expect more defensiveness than in adoption, is encouraging.

A third assumption is: Research participation by an agency can be a source of confidence to many clients. While most people know little of research methods and techniques, the word research and the notion that it implies systematic study and evaluation are very familiar.

Much of the prestige gained by research in the physical sciences also carries over to work in the social sciences, although in these areas human behavior presents a different set of problems. The participation of an agency in a research program can be presented to clients as an indication that it is keenly interested in improving its agency operation. Any agency interested in research should not have to apologize to its clients or board members for this interest, but must be careful to avoid the charge of "guinea pigism."

Obstacles in Planning Research

The assumptions that adoption is socially approved, that adoptive parents accept and even welcome occasional contact from the agency following the period of supervision, and that research participation is a source of confidence to the client affect the planning of research. If it is agreed that these concepts are valid, a number of specific practical

studies in the adoption area should be feasible.

There are several obstacles frequently mentioned as important in the planning of any research, including studies of adoption. A serious problem is presented by the wide variations in agency practice. Not only do agencies do things differently but the same agency will operate in various ways as executives and staff change and as new ideas emerge. Sometimes too much stress is placed upon the possible effects of differing agency practices. While it is necessary to recognize differences, there is no reason to assume that they make research impossible. They do make it imperative that the organizations participating in studies formulate an accurate statement of their own procedures and philosophies, and describe their setting carefully to prevent inappropriate generalization of results.

Another obstacle to research which is typical of social work, as well as of clinical psychology, medicine, and other services, concerns the limitations of case records. Follow-up studies are often necessarily limited because records may not be suitable for certain research problems. All possible use should be made of present records. For many research purposes special recording methods must be set up for a particular project. We cannot expect to arrive at a prefabricated case recording system that will answer all demands of care, supervision, and research. Brevity alone would often make case recording more useful for research. Thus the planning and the results of adoption studies should have many implications for case recording practice. Some of the difficulties involved in varying agency practice and differences in case records can be taken into account through the use of several agencies to conduct parallel studies.

Another obstacle is implied by the comment that since there are so many non-agency placements, research in adoption agencies tells too little. Certainly independent placements must also be studied carefully in a comprehensive research program. At the present time, however, it is in the agency

setting that the most satisfactory research can be designed involving the needed control and required parental cooperation. It seems reasonable to be interested in good agency practice first since this is generally the most acceptable way for adoption to take place. Not only do the agencies offer professional staff who have special interest in the problem, but one can also expect more cooperation from individuals who are willing to accept the safeguards to both child and parent which the agency provides.

The purpose of the remainder of this discussion is to indicate four different ways in which adoption research can be undertaken, and to present suggestive questions which such research may be expected to answer. These questions are in no way inclusive of all the important issues but provide a point of departure for research planning.

(1) Adoption research previous to the initial interview.

Many adoptive agencies receive their first contact from potential applicants by telephone or letter. It would be helpful to caseworkers to have more knowledge of the expectancies of applicants for adoption. Not only would this make possible better rapport but also would indicate how well the public understands the operation and objectives of the adoption agency and might suggest, depending upon the outcomes of the research, that more effort should be made to increase public information and understanding of the work of the agency.

Perhaps agencies have been unwilling to consider research previous to the initial interview because they feel that the emotional state of the applicant would make such a project inadvisable for the client. The usefulness of the method could easily be explored first on a pilot basis.

Between the time the initial contact is made and the first interview, a questionnaire could be sent to the potential adoptive parents to be filled out anonymously and returned to an independent group such as a welfare council research division. Such an arrangement would make it impossible for

applicants to be identified individually. It would be clear then that information given would not be used in deciding whether an application will be approved. However, since the prospective parents are interested in receiving a child from the agency, the percentage of returns should be higher than in the usual questionnaire study. Several general follow-up methods could be used to encourage return of the questionnaires.

Some of the areas that could be included are indicated by the following questions:

How did the couple become interested in adoption from this agency?

What advantage do they see in agency placement compared to independent placement?

What has been their previous contact with people who have adopted children through this agency and from others?

With what personal factors do the applicants feel the agency will be concerned, e.g., income, housing, health history, etc.?

How long do the applicants think it will take for a child to be placed with them?

What do they see as reasons for refusing to consider a couple as prospective adoptive parents?

What is the sex preference of a child by these applicants? Why?

How much contact do they expect to have with the caseworker and what do they see as its purpose?

What do the applicants consider to be the agency's reason for charging fees (if it does so)? What is their attitude toward the practice?

(2) Study by follow-up of completed adoptions.

A study of completed adoptions can provide information in many areas including parent-child relationships. The questions presented below are suggestions for research involving the parent. A similar group of questions could be developed for studies on adopted children.

Parental satisfaction: Do the parents consider the adoption to be generally successful? What are their specific qualitative reactions after various periods of time? Were they satisfied with the agency supervision? What suggestions would they offer concerning supervision?

Matching: If matching of physical characteristics was an aim in the agency's practice, does it appear that this was done successfully? Do the parents feel that there is a physical resemblance? If not, is it a source of concern for them?

Sibling relationships: Have there been natural children born to parents who are not clearly sterile (e.g., as a result of hysterectomy)? Have the parents tried to adopt another child? Were they successful? What can be learned about sibling problems?

Identity: Have the parents received questions from the child concerning his identity? Did the fact of adoption come up if "Where did I come from?" was asked? Has the child been told about his adoption? If so, how? Do the parents feel they have succeeded in this? Does the fact of adoption come into disciplinary situations?

Specialized help: Have the parents felt any need for specialized help with the child? Have they made efforts to seek such help, and have the efforts been successful? To what extent have these children been referred to child guidance facilities in the public schools or other community agencies?

Source of referral: Have these parents been able to provide help to other people who have wished to adopt?

(3) Study of current adoptive placements and pending applications.

Here it is possible to bring about the greatest degree of control and to get at variables with more success than in the follow-up method, although it will mean that the research must be extended over a substantial period of time. Not only can many of the questions above be dealt with but there are additional possibilities:

Does the study of the adoptive parents provide the basis to make predictions about parent-child relationships? Can personality testing be used more successfully to predict parent-child relationships?

How important is matching to adoptive applicants?

What are the areas of concern shown by questions most frequently asked by adoptive parents in the initial interviews? What are those areas typically discussed with the caseworker at the time of regular visits?

What factors are used to determine whether or not a couple is considered a good adoptive possibility? What agreement is there from worker to worker?

Are the observations of two caseworkers who may share the responsibilities of giving help during the period of supervision valuable for gaining additional insight into the adoption process?

Is there any relationship between factors in the fertility study and the ultimate success of adoptions?

How are attitudes toward illegitimacy related to successful placements?

(4) Follow-up of rejected applicants and those who withdraw before agency action is completed.

Much knowledge is needed of how skillful agencies are in getting couples whom they

consider poor risks to give up their interest in having a child. It would also be helpful to see how frequently these clients are able to adopt by other means.

What is the expressed attitude of the applicants toward being rejected?

Were applications to other agencies made before the rejection or withdrawal? After the rejection or withdrawal?

Does the couple now have children? How were they secured?

A special research technique that has received considerable attention is electronic recording. Where it is helpful to have a verbatim record of what took place, for example, in an intake interview, this method is ideal. Although there is a period of self-consciousness during the first few minutes of recording for many clients, this does not last long. It is unusual for anyone to refuse to have material recorded once he is assured that it will be kept in confidence. No evidence has been presented that the use of recording is detrimental to the client or to the client-worker relationship. Many professional workers are probably the victims of a cultural lag since a number of the clients with whom they work have access to such equipment and may use it extensively.

Difficulties come in the handling of recordings once they are made. Editing is a tedious job and may be highly subjective. Recording no doubt will have its place in adoption research although the criteria for editing recorded material must be set up carefully.

To have complete recordings of intake interviews with varying sorts of adoptive parents could indicate how various workers weight factors revealed in the interviews and their agreement on criteria of selection of adoptive families. These recordings together with face-sheet data would make it possible for caseworkers to analyze the same material. The same question might also be studied using written case records and the results compared. Problems in making decisions on applicants might be seen quite differently if there is high agreement among workers from various agencies on who are good adoptive prospects and who are not, or if they disagreed among themselves after evaluating the

same interviews. Electronic recording has been considered here only as an illustration of the need to use the newer research tools whenever they are particularly appropriate.

Since there is considerable interest in adoption research, agencies should readily find adequate local resources from foundations and individuals to carry on studies. It is important that such studies be coordinated on the national level to prevent unnecessary duplication and to provide the highest degree of integrated effort.

Research on adoption should begin in those agencies which are considered to have policies and procedures representing the best methods—best in terms of current casework practice-theory. The main problem may be getting research under way with a high level of agency interest. A stumbling block comes because some of the basic problems cannot be

translated immediately into the findings which are useful to the agency. Certain research projects can well be done by graduate students but in these instances difficulties result if the aims of the thesis advisory committees and those of the agency are different. Along with research that is immediately practical, agencies have an additional responsibility to cooperate in fundamental studies which may seem academic but which in the long run will make their contribution to the practical working of the agency. Likewise, staff members of colleges and universities have a responsibility to make research designs as practical as possible in the interests of the agencies that they will want to help supply data.

The need for coordination at the national level is imperative to the success of a research program in adoption.

SERVICES TO UNMARRIED MOTHERS

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In this article the author discusses the efforts of a children's agency to provide adequate services to meet the specific needs of the unwed mother.

WITH ALL that has been written and said of the problem of illegitimate pregnancy, it continues to hold a special place among the many personal and social problems which concern us in the field of social casework. Perhaps one reason, over and above the critical nature of the problem and the variety of services needed, is the time-limited nature of the problem. Frequently we have only a brief time to work with the girl before the baby is born and a vital decision must be made. We no longer rationalize that the baby can be tucked away in a foster home for a few years and that in time everything will work out.

We recognize unmarried motherhood as a symptom of a more pervading personality

difficulty. We accept the uniqueness and complexity of the girl's personality and concur that successful casework help is based on our understanding of the particular client. But successful casework help is dependent upon an environmental situation fairly free of conflict, anxiety, insecurity. I would like to offer for consideration some facts about the "environment" provided for the unmarried mother by Children's Bureau, and some of the possible effects in the over-all service to the client.

Agency's Service Goals

When we instituted our program of services to unmarried mothers at Children's Bureau in 1948, we were in a sense "grop-

ing." Our foster home program was long established and from our experience we were confident we could provide adequately for the care of the baby. We had little difficulty in arranging for good medical care for both resident and non-resident girls regardless of race and religion. However, our concern centered on working out adequate living arrangements for the unmarried mothers and in setting up a plan for financial assistance which would come within the agency's budget and at the same time meet the basic needs of the clients during the periods of financial need. White girls for whom maternity home care is indicated are referred for complete service to one of the various local maternity homes. Our service is to girls who wish and can use an independent living plan or a foster boarding home.

Over and above the problems of establishing appropriate resources for the client, which were primarily administrative in nature, our attention was focused on the quality of casework service, requiring skilled caseworkers, adequate supervision, psychiatric consultations, and limitation of case load.

Having obtained these essentials for good services, our attention over the past few years has been in testing the value of the services in terms of the individual client. At the same time we have gathered some tangible facts directed toward a better understanding of the over-all picture. While these facts are primarily of value in the administrative aspects of the service, there does seem to be some correlation between them and the experiences of the individual client. These data, consisting mostly of some isolated facts, permit little more than a few speculations.

Where do our clients come from? While Children's Bureau has no residence requirements, residence is a factor which we have needed to consider both administratively as well as in plans with the individual client. Illegitimate pregnancy by its very nature frequently impels the unmarried mother to seek service elsewhere. The girl in the small town attempts to find anonymity in the city. Motivated by her need, she is not cognizant

of such factors as eligibility requirements for public assistance and for free medical care. She has not heard of such problems as "hard to place" or "unadoptable" babies. How can she know that, because of limitation of funds, private agencies must look first to meeting the needs of clients living within their jurisdiction?

The following table gives the breakdown of clients served by Children's Bureau 1951-1954 in regard to residence.

Table I
Residence of Unmarried Mothers Served by Children's Bureau During the Period 1951-1954:

Residence	Year			
	1951	1952	1953	1954
Residents	19	26	46	45
Non-Residents	50	61	55	54
Total	69	87	101	99

We have used the term "residents" to include unmarried mothers, regardless of age, who have made their home in the New Orleans area for a year or more before becoming pregnant.

The majority of non-resident unmarried mothers came to New Orleans in an effort to conceal their pregnancy from family or friends, waiting until their arrival to seek help with their problem. In the past two years, however, there has been an increase in the number of non-resident applicants referred by their local agencies. Of the fifty-five non-residents accepted for service in 1953, ten were referred by an out-of-town agency. In 1954, seventeen of the fifty-four accepted were by referral. Rarely are these clients able to carry the cost of their medical care and they usually need help in financing their living expenses.

It is evident from these data that while the ratio of unmarried non-resident clients has continued high, the growth in the size of the program is in service to local clients.

Effects of Fear of Discovery

This increase in applications from local girls has presented real difficulties in working out adequate plans. Many of these clients are fearful of discovery and anxious for a plan

away from New Orleans. Unless the client has resources to cover transportation and cost of care, it is usually not possible to work out referral for her. It is encouraging that attention is being given this problem, which, no doubt, is faced by all of us offering service to unmarried mothers. The client who must go through her pregnancy in constant fear of discovery is often too preoccupied with these fears to make maximum use of casework help and secondly, there seems little doubt but what her having to remain has its effect on her decision about her baby. When faced with the fact that we are unable to arrange for their care away from New Orleans, some clients withdraw from service, feeling there is no hope of concealing their pregnancy. A recent example was:

Jean, a young girl of good standing in the community, was unable to finance cost of care away from New Orleans. To call upon her parents, who lived in another city, would necessitate her telling them of her condition. Seeing no alternative, she told them and acceded to their request that she return home and keep the baby.

In lieu of a better solution, it is possible agencies with limited funds may need to consider curtailing their services to non-resident clients in order to allocate funds to finance services for their local clients elsewhere.

Most clients applying to us for service feel pushed and anxious for both a living and a medical plan as soon as possible. This calls upon the worker's skills in arriving at a diagnosis of the client's difficulties, strengths and weaknesses, and of her capacity to use casework help. The fact that the unmarried mother has one caseworker from the initial contact through completion of service, enables her to consider with one worker the various facets of her problem and to decide such matters as living plans, medical care, and her decision about the baby. Others who share concern in the girl's problem such as the baby's father or parents are usually assigned a separate worker.

Age Influences Mother's Needs

One of the first decisions to be made by the worker and client is whether or not the

agency's resources are appropriate to meet her needs. Can she safely go through her pregnancy living alone? Can this client benefit from life in a private boarding home, or would maternity home care seem more suitable for her? While each decision must be reached on the basis of the over-all factors involved, there are certain facts which must be taken into consideration. The girl's age may strongly influence the choice of both living and medical plan. The young adolescent lacks the maturity to meet the responsibilities and problems of living independently. On the other hand the unmarried mother in her thirties who has been living independently for years may find adjustment to group life an additional pressure. It may not be medically sound for the girl with physical difficulties to live alone.

The following table gives the age distribution of clients served by the agency over the past three years.

Table II
Age Distribution by Per Cent of Unmarried Mothers Served by Children's Bureau During 1952, 1953 and 1954 by Race:

	1952		1953		1954	
	White	Negro	White	Negro	White	Negro
Total	100%	100%	100%	100%	100%	100%
13-16	3.30	29.2	0	27.	0	24.2
17-20	22.	41.6	31.1	34.6	28.8	41.4
21-24	30.5	25.	28.4	30.8	24.1	27.6
25-28	18.6	0	14.9	3.8	18.1	3.4
29-32	12.2	0	16.2	0	17.	0
33-36	3.3	0	4.	0	6.	0
37-40	5.1	0	4.	3.8	4.5	3.4
41-44	0	4.2	1.4	0	1.5	0

The consistently high per cent of Negro girls twenty or under has served to substantiate our conviction as to the importance of developing foster boarding homes, particularly for our Negro clients. Fortunately, we have been able to develop sufficient good boarding homes to meet the needs of most of our Negro unmarried mothers. Homes for white girls have been harder to find. In studying boarding parents we have applied the principles used in selecting foster parents for children with two important differences: we have not approved homes for unmarried

mothers when the couples have children of their own living at home, and for the care of unmarried mothers we are more ready to approve the home of a woman living alone. As with children's foster home applicants, we recognize the importance of understanding the motivations.

With the young client, the experience in the boarding home often provides a corrective emotional experience. We work closely with the boarding home mothers so that the "acting out" behavior and emotional responses experienced with the boarding parents become an integral part of the therapy. These young girls, often still tied dependently to family, are frequently too threatened to deal with their feelings toward their own parents, but are more ready to recognize their patterns as they are experienced with the boarding parents. We have often found it helpful to draw the boarding mother into the treatment plan, i.e., to help her see how the client has brought with her certain patterns of behavior and how these relate to her behavior in the boarding home. For example:

Meg, an unusually tall, heavy-set girl, had been adopted as a child by an ambitious dominant woman. It had been instilled in Meg that she should be forever grateful for having been rescued from a degraded family who didn't want her. Meg, from childhood, had done all the cooking and housework while her adoptive mother followed her career. In the boarding home Meg presented herself as strong and able. She attempted to take over the running of the home, even to such vigorous tasks as re-upholstering furniture, repainting window boxes, etc. In discussing Meg with Mrs. Rose, the boarding mother, the worker asked how she saw Meg. "She certainly is an able and industrious woman." "Woman? Would it surprise you to know Meg is only 18?" "She is? I can hardly believe it. Why she's only a kid." This led Mrs. Rose to perceive underneath the facade of adequacy many incidents in which Meg's underlying craving for dependency gratification was evident. With little assistance from the worker, she went on to plan ways in which she would demonstrate to Meg that it was not necessary to buy her love and acceptance through playing a servant's role.

Old Patterns Re-established

A good foster boarding home is particularly helpful to the young unmarried mother who has had inconsistent responses from her own parents—most often a combination of indulgence and strict discipline. Once the

newness of the placement has worn off, we begin to see the girl's attempts, either directly or indirectly, to re-establish her former patterns. She may attempt to use her pregnancy as a rationale for her demands to be indulged. "My side hurts—I just can't wash out my underthings today." "I feel weak, I just can't come to the table to eat." Some, under the guise of not knowing better, go to rather extreme measures to act out their hostility. More frequently, it takes the form of breaking dishes, damaging appliances or "messing things up." Rivalry with the boarding mother for first place with foster father is not uncommon. It has been our experience that the "best" boarding home mother needs much help in recognizing the meaning of the girl's behavior and her own reactions to it; otherwise she may find herself caught up in the girl's patterns. While there seems to be value for the client in experiencing love and acceptance in combination with firm but reasonable limits, these gains become truly meaningful as the worker helps her to become aware of the relationships between her current feelings and reactions and the earlier situation in which they were formed.

These young girls, hungry for affection, tend to form a deep attachment to the boarding mothers and almost invariably express a strong wish to live indefinitely with them. Generally the unmarried mother remains in the boarding home for about six weeks following delivery. During this period she has the caseworker's assistance in making permanent living arrangements and in choosing a type of work which will bring satisfactions. On occasion the very young client is allowed to remain in the boarding home and to continue her schooling. Often much of the gains would be lost if these girls, as yet too young to work and live independently, were obliged to return to their parents' homes. The girl who "acts out" her problems through illegitimate pregnancy in early adolescence frequently comes from a home that has little to offer her. The boarding parents can be of great help to these young girls in developing an ethical code and in arriving at realistic goals for themselves.

While we are unable to make any direct correlation between the experience in the boarding home and the decision the girl makes for the baby, there has been evidence that the experience has tended to help the unmarried mother reach a more objective evaluation of her relationship to her own parents and to further her emancipation.

Older Mothers Prefer Independence

Returning to table No. II we note that among both white and Negro girls the largest number falls within the seventeen to twenty-year interval, (except for the Whites in 1952). However, in contrast we note the number of white girls sixteen or under was negligible and secondly, that from forty to forty-seven per cent were twenty-five years of age or over. Among these older clients served by the agency, there were wide variations in background and in the degree of emotional difficulty, but for the most part they were girls who had been making a living independent of their families. Almost invariably these clients strongly insist on an independent living plan. They usually prefer a small apartment to a room and board arrangement. They frequently express interest in cooking and "fixing the place up." Not infrequently they collect pets. We might speculate the pregnancy has aroused underlying feelings of guilt and inadequacy and that this insistence on an independent living arrangement is a defense against their regressive impulses. Study of the case situations in the agency where an independent living plan was used, suggests that the client's dependency needs were met primarily through the relationship with her worker and that ego strength was bolstered in demonstrating her ability to live independently.

Basic to the psychology of women is the sense of fulfillment or completion derived from pregnancy and childbirth. The affectionate interest and approval of husband, family and friends; the collecting of baby things; choosing a name—all serve as sources of gratification. The unmarried mother usually experiences a sense of frustration in realization of these feminine strivings. To her

the birth carries guilt, shame and painful decisions—often only a baby she must give up. We have noted in our unmarried mothers a new enthusiasm in cooking, particularly pastries and other sweets. Might we speculate they may use adventures in cooking and housekeeping in reaction to this frustration, thus gratifying their needs at an oral level; in a sense not only mothering themselves but giving expression to their own longings to mother a child. The fact they are free to exercise their own judgment and freedom of choice may further maturation—strengthen ego functioning. Their transition back to their usual life of work or school may thus be facilitated. The interest and approval of the caseworker in these day-to-day matters may go far in correcting self-deprecating attitudes experienced earlier with their own mothers. Recently one girl who had lived a very unstable, chaotic kind of life, told her worker that finding she could live and manage on a budget had given her morale a big boost. An independent plan is used only when the client feels comfortable in this and when there are no contraindications medically or psychiatrically. The fact the girl has the home phone number of her own worker as well as one other worker provides some safeguards. Usually the girl is on friendly terms with the landlord or a neighbor who are helpful upon her return from the hospital. In those situations where the unmarried mother cannot accept the offer of temporary foster care of her baby and takes her baby home with her from the hospital, efforts are made to obtain some extended hospital care.

Certainly, foster boarding home care or an independent living plan is not an answer for all girls, but when used appropriately we feel has many therapeutic values.

Mother's Decision for Baby

One aspect I have not yet touched upon is in the area of the decision the mother makes for her baby. We feel our big advantage of service to the unmarried mother given through an agency providing foster home care for children lies in the fact that the needs of both mother and child are more easily kept in

focus. We hold with the philosophy that foster care of the baby should be offered as a temporary plan, the extent of which should be agreed upon with worker and mother—usually two or three months. The worker is free to extend this period when, after careful evaluation, it is evident that the unmarried mother is using casework help in working toward a decision. From our own experience we have learned to guard against playing into the mother's ambivalence in making a final decision or to our own needs as a basis for extending foster care.

It would be helpful in our practice if more were known about the relationship between the role taken by the girl's mother in regard to her pregnancy and the decision which the unmarried mother makes for her baby. What factors motivate a girl to share her problem with her parents, particularly her mother? How often do these mothers attempt to influence the girl in her decisions? Are there significant changes in the unmarried mother's relationship with her family during or after pregnancy? We have observed a strong desire on the part of the unmarried mother to return home at least for a visit as soon as possible following delivery. This pattern has been evidenced even in girls whose bond to family is primarily negative and who have lived away from home for a number of years. Are they motivated primarily by a need to be forgiven or by a need to see the mother in order to reassure themselves their hostile, destructive impulses and phantasies—brought to awareness during the pregnancy—have not in fact, damaged or destroyed the parents?

Conclusions

This analysis points up some of the problems relating to the residence of unmarried mothers. Children's Bureau, like many other agencies, faces a real problem in planning adequately for some of its local clients. The shortage of adoptive homes for Negro children which exists over the country presents an additional difficulty in referral of Negro unmarried mothers. Is it not time we develop a system of reciprocal services?

In discussing the factors which bear consideration in meeting the needs of the unmarried mothers, I have suggested age and capacity to live independently as criteria in

the choice of living plans, i.e., a foster boarding home, an independent living arrangement or maternity home care. It has been our experience over the past seven years that an independent living plan not only tends to strengthen the client's self-confidence, thereby minimizing regressive tendencies, but also to build ego strength during pregnancy. The fact that she has established herself as a member of the community facilitates the transition back to an independent life. She may feel less set apart by her pregnancy.

Foster boarding homes on the other hand have been used to advantage in offering a corrective emotional experience, particularly to the adolescent unmarried mother. Her day-to-day experiences in the boarding home form an integral part of the therapy. We see as one of the chief values of our program the fact the unmarried mother has the continuing relationship of one worker throughout the contact. With the exception of the help given her by the medical social worker at the hospital, the various facets of her problem form an integral part of the whole casework process.

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A BOARD MEMBER SPEAKS

How to Keep Out of Mischief Between Meetings

IN THE January issue of CHILD WELFARE Mr. Clyde Getz has told the story of the successful resistance to a recent attempt to weaken the safeguards in California's adoption statutes.* His account is valuable and accurate, except that, with characteristic modesty, he has concealed his own great contributions to the happy outcome. He writes, of course, as a professional worker; and it has been suggested that a few further comments from the point of view of a board member might help to round out the picture. Hence these remarks, by way of footnote to Mr. Getz's statement.

In these days of skilled professional social work, a board member is likely to wonder from time to time just what he is good for anyway. Of course, we all know that the board is the legal governing body, exercising the corporate powers of the agency; but these duties are performed collectively, at meetings only. The board also selects the executive, but fortunately the necessity to do that does not arise often—perhaps not at all during a particular member's entire tenure. It is up to the board to see to it that there are enough funds available to keep the agency running; but in highly organized communities this may require nothing beyond an annual appearance by a delegation from the board before a Community Chest Budget Committee. The board is responsible for policy, as distinguished from administration; but if the agency is running smoothly and harmoniously, and if the executive is all that he should be, most policy questions will be presented by the staff, and will be resolved only with the benefit of the recommendations of the professionals. In his most honest moments of introspection, the board member may well ask himself what he is actually doing to earn the phrase "community leader"

that will appear in his obituaries, except to turn up on the third Tuesday of each month and say "Aye" at reasonably frequent intervals.

An episode like the need to engage in a legislative controversy helps to answer that disturbing question. It illustrates in somewhat dramatic fashion the most important aspect of the board member's function. He sits on the board as a representative of the community; he is there because the community needs and wants a particular activity carried on, and someone has to take on the job of seeing that it gets done, and done properly. Each member is such a representative, and he does not cease to be one in the interval between meetings, any more than a congressman ceases to be the representative of his constituents during the recess between sessions. In that very real sense, the board member is on duty and on call constantly, and especially when the agency, or its work, or its good name, is in any way attacked or threatened. His service must be measured, not just by what he does, but by what he is. Out of conviction, he has assumed a status, not knowing just where the obligations of that status may unexpectedly lead him. Duty may draw him to the state capitol, or further; on the other hand, the calls upon him may be extremely slight. That does not matter; what is important is that he has assumed the responsibility and recognizes it.

I would not advise a board member who is also trying to carry on a business, or practice a profession, or run a home, to get into legislative struggles very often; he is likely to find them rather time-consuming. He will also, however, find them stimulating and rewarding—especially if they turn out well. And he will no longer have to ask himself the question "What can I do to be of use between board meetings?"

FRANK H. SLOSS

*1st Vice-President
Children's Home Society of California
Los Angeles*

*Getz, Clyde, "Citizens Speak on Adoption Legislation in California," CHILD WELFARE, January, 1956, p. 13.

BOOK NOTES

New Hope for the Retarded, by Morris P. and Miriam Pollack. Porter Sargent, Boston, 1953. 176 pp. \$4.50.

This book undertakes to describe in detail the actual day-to-day techniques employed in the management and training of retarded children. Unlike most books on the subject of mental deficiency, it is written by teachers who have themselves been engaged for a long period of years in the actual rehabilitation work they describe. After briefly discussing certain general principles designed to show that retarded children can be helped to occupy a happy and useful place in the world, the authors discuss techniques of home training for the use of parents, tactics of speech training, and methods for promoting the socialization of the child both in and out of the home. Much attention is given to the special procedures used in residential care; the advantage or necessity for such care is discussed in a sensible way, with a pervading assumption that integration into the family and later into the larger society is the desirable goal. Among the features of the book are its many simple but effective drawings and illustrations, its detailed description of a variety of educational devices, its brief but interesting case reports and anecdotes, and the valuable selection of entertainment items used for children's functions.

A mere clinical psychiatrist accustomed to dispensing ex cathedra judgments to the distressed parents of retarded children should view a book of this sort with a certain humility, since clinical psychiatry unfortunately not only demands no practical educational experience but imposes no obligation to acquire it. This is an area in which the special teacher, armed with his own experience and understanding, must step forth to claim his right to be heard. But unfortunately teachers, for their part, are too often forced to rely on a hard won empiricism with none of the advantages that sound theory based on scientific knowledge could provide. From this point of view it is unfortunately easy to pick

flaws in this treatment of the "retarded child." What retarded child one might ask. Is the child with diffuse cortical damage resulting from asphyxia at birth to be treated like the motor aphasic child with a circumscribed left frontal lesion? Or is the child, whose physiologically defective neural integration leads to emotional or behavioral disorders, to be treated like the retarded child whose frustration or rejection leads to secondary neurotic difficulties? This indifference to diagnostic categories is especially distressing in the chapter on speech therapy, for no distinction is made among the aphasic, the dull and unresponsive, the hysterically mute or the child with hearing loss. There is room for a closer collaboration of the medical and educational experts for greater refinements of diagnosis and management.

A further limitation of the book is its apparent preoccupation with children who could be most accurately described as slow learners or mildly but definitely educable retardates. This limitation is also reflected in its concern for academic achievement of an abstract character divorced from more readily comprehended functions. This gives the educational content a certain mechanical character with too little relation to the daily life and needs of the child. One could also query the authors' apparently uncritical acceptance of the I.Q. or their use of certain conventional descriptions of the Mongoloid child. They also place too naive a reliance on private industry to provide vocational opportunities for the handicapped.

This popular, undifferentiated and somewhat mechanical approach to the problem of training limits the value of what might otherwise be regarded as a very good instruction book. The authors have the kind of warmth, patience and enthusiasm for the work that makes their success seem plausible. It is a book that contains many useful ideas for parent, teacher, and doctor alike, in their management of a certainly frequently encountered type of mildly retarded child. It may, however, lead to pitfalls and dangers if

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its lessons are applied too generally to the "retarded" child.

JOSEPH WORTIS, M.D., *Director and*
ELSE HAEUSSERMANN, *Educational Consultant*
Div. of Pediatric Psychiatry, Jewish Hospital of Brooklyn,
N. Y.

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A Tiny Baby For You, by Nancy Langstaff and Suzanne Szasz. Harcourt, Brace and Company, New York, 1955. Unpaged. \$2.50.

This book was written when Mrs. Langstaff wanted her young son Johnny to look forward to the arrival of the new baby in the family. Feeling that talking to him was not enough and not being able to find in either books or magazines just what she wanted, she and her friend Suzanne Szasz developed their own book for Johnny and other small children.

A Tiny Baby For You is written in very simple text and accompanied by exceptionally clear, good photographs.

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Stuttering in Children and Adults, edited by Wendell Johnson, assisted by Ralph R. Leutenegger. University of Minnesota Press, Minneapolis, 1955. 472 pp. \$5.00.

Stuttering in Children and Adults reports a series of research studies on the causes and treatment of stuttering. Experimental research on the problem began at the University of Iowa in 1924, and since then Iowa has developed one of the leading centers for the study of stuttering.

The book contains 43 papers that have resulted from this research program. Forty-one different contributors are represented in the series of reports. Much of the work centers on the onset of stuttering in children and underlies the theory that stuttering begins with the hearer rather than with the speaker. In a summing-up of his theories, Professor Johnson advances the view that stuttering is what the speaker does in trying to keep from stuttering again.

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The Nursery School, by Katherine H. Read. W. B. Saunders Co., Philadelphia, 1955. 297 pp. \$4.00, 2nd ed. 1st edition reviewed in *CHILD WELFARE*, November 1951.

CLASSIFIED PERSONNEL OPENINGS

Classified personnel advertisements are inserted at the rate of 10 cents per word; boxed ads at \$6.50 per inch; minimum insertion, \$2.50. Deadline for acceptance or cancellation is eighth of month prior to month of publication. Ads listing box numbers or otherwise not identifying the agency are accepted only when accompanied by statement that person presently holding the job knows that the ad is being placed.

PHOENIX, ARIZONA—Casework vacancies for experienced graduate workers in family agency. Salary \$3600–\$5500. Appointment salary dependent on qualifications. Write Mrs. Ella H. Perkins, Executive Director, Family Service of Phoenix, 702 E. Adams St., Phoenix, Ariz.

EXECUTIVE SECRETARY for child care and placement agency, to be responsible for administrative relationships with board, staff and community. Must be graduate social worker with administrative experience. Starting salary \$5000. Write Mrs. Harry Harpham, Chairman of Personnel, Arizona Children's Home Association, 365 Indian House Rd., Tucson, Ariz.

CASEWORKER, Master's degree, to work with parents and children in foster homes and cottage placement as part of psychiatrically oriented team. Car necessary. Good supervision and working conditions. Adequate psychiatric consultation, retirement plan and Social Security, paid hospitalization insurance. CWLA member. Salary \$4092–\$5112. Can hire at \$4572. Write Karl Freeman Glou, Vista Del Mar Child-Care Service, 3200 Motor Ave., Los Angeles 34, Calif.

CASEWORKER, Catholic, professionally trained for progressive family and child welfare agency. 20 miles south of San Francisco. Salary \$3780–\$4704, can appoint at \$4704. Social Security and retirement benefits. 1 month vacation. Good supervision and psychiatric consultation. Apply Catholic Social Service, 112 N. San Mateo Dr., San Mateo, Calif.

SAN FRANCISCO, CALIFORNIA: Openings for three caseworkers with graduate training in expanding family and child welfare agency with professional staff of 65. Multiple services including marital counseling, homemaker service, financial assistance, child-placement in foster home care and group care, specialized adoption program, psychiatric consultation. Highly qualified supervision. Standard personnel practices. Opportunities for advancement. Field placement for graduate students University of California. Modern, attractive offices. Salary \$3600–\$4872 depending on training and experience. Write Rev. James M. Murray, MSW, Executive Director, Catholic Social Service of San Francisco, 1825 Mission St., San Francisco, Calif.

CATHOLIC WOMAN SOCIAL WORKER needed in unwed mother program; Master's degree with experience; age 28-45 years; salary range \$4596-\$5712 per annum; apply to Director, St. Elizabeth's Infant Hospital, 100 Masonic Ave., San Francisco, Calif.

CASEWORKER in small private children's agency offering residential and foster home programs; services to unmarried parents; adoptions. Good supervision; psychiatric consultation; opportunity for professional growth. Requirements: Master's degree social work school; experience in adoption desirable. Woman. Can appoint at salary of \$4500. Miss Gertrude Breese, Woodfield Children's Village, 1899 Stratfield Rd., Bridgeport 29, Conn.

CASEWORKERS (2)—Family Caseworker, Litchfield County Office. Challenging opportunity in District Office which is adding family service to child-placing services. Work with community involved as well as casework with parents and children. Child Placement Caseworker in Fairfield District Office which offers family, unmarried mother and children's services. (Office located in Danbury.) Private nonsectarian, statewide, multiple-function agency. Small case loads, excellent supervision, student training program, psychiatric consultation. Master's degree social work and preferably some experience required. Salary scale \$3800-\$5300. Please write Miss Verne Weed, Assistant Executive Director, 1680 Albany Ave., Hartford, Conn.

CHILD WELFARE WORKER in local public welfare department to carry casework services and placement in subsidized foster homes of children referred to department and to work with unmarried mothers. Requirements: Master's degree social work school, or one year in school of social work plus one year social work experience. Salary \$4160-\$4992. Complete details by writing to Director of Personnel, Municipal Bldg., Hartford, Conn.

CASEWORKER—Residential treatment center for emotionally disturbed children, Hartford. Private, nonsectarian, statewide, multiple-function agency. Small case loads, excellent supervision, student training program, psychiatric consultation. Master's degree social work and preferably some experience required. Salary scale January 1956, \$3800-\$5300. Please write Miss Ruth H. Atchley, Assistant Executive Director, 1680 Albany Ave., Hartford 5, Conn.

CASEWORKER in multiple-function, private, nonsectarian, child welfare agency. Case load of emotionally disturbed children in institutional setting. Psychiatric consultation. Good personnel practices. Top salary limit \$5600. Minimum requirement: two years' graduate social work training. Complete details by writing Anna K. Buell, Casework Supervisor, Children's Center, 1400 Whitney Ave., New Haven, Conn.

CASEWORKER—Master's in social work, for adoption work in multiple-service agency. Salary range being revised, can appoint at \$4800 if experience warrants. Psychiatric consultation. Social Security, retirement. Eleanor Sheldon, Family & Children's Services, 79 Worth St., Stamford, Conn.

FLORIDA—SUPERVISORS AND CASEWORKERS—All pioneering is not in the West. Florida, the fastest growing state in the new industrial South, is building dynamic and forward-moving social services. Far from being just a place to which to retire, Florida offers many opportunities to younger people as a place to live and work. Youthful, professionally trained caseworkers and supervisors are needed in several Florida cities in statewide private agency offering adoption placement and related services. Agency now under professional executive leadership of Walter R. Sherman. Appointment salaries range \$3600-\$5500, depending on experience and job responsibility. Write Miss Cornelia Wallace, Associate Director for Casework, CHILDREN'S HOME SOCIETY OF FLORIDA, P.O. Box 5722, Jacksonville 7, Fla.

ST. PETERSBURG, FLORIDA. Caseworker in children's agency offering foster home and adoption placement. Requirements: two years' graduate training, or one year's training plus one year's child welfare experience. Salary range \$3600-\$5280, depending on qualifications. Write W. L. Wilson, Children's Service Bureau, 440 Second Ave., North, St. Petersburg, Fla.

CASEWORKER—Opening for professionally trained person with or without experience, in agency offering homemaker service and counseling to families and individuals. High professional standards; good supervision; excellent personnel standards. Salary for beginning worker \$4500; for others, on basis of experience. Write Miss Marguerite M. Munro, Family Service of Savannah, 109 W. Jones St., Savannah, Ga.

CASEWORKER. Opening in family children's service agency for qualified caseworker. Salary range comparable with good agency practice. Information upon inquiry. For further information write Director, Catholic Social Service Bureau, 475 Orange St., New Haven 2, Conn.

COUNSELING POSITION in institution, boys 6 to 18 years of age. MS and at least 3 years of casework required. Salary range \$4000-\$4500. Write Mr. Charles R. Aukerman, Executive Director, Lawrence Hall, Inc., 4833 N. Francisco Ave., Chicago 25, Ill.

CASEWORKER in multiple-function Protestant child care agency, CWLA member, one hour from Chicago, good supervision and personnel practices. Graduate trained, salary commensurate with experience. Maintenance if desired. Robert I. Beers, Director, Lake Bluff Children's Home, Lake Bluff, Ill.

CASEWORKER for progressive children's agency with cottage-type institutional facilities and foster home program in Chicago area. Member CWLA. Excellent personnel practices, psychiatric consultation, good salary, plus pleasant living quarters and meals. L. B. Snider, Executive Director, Central Baptist Children's Home, Lake Villa, Ill.

PROFESSIONALLY TRAINED CASEWORKER for undifferentiated caseload family and children's agency. Good supervision and personnel practices. Good salary depending on training and experience. Write Luna E. Kenney, Director, Family and Children's Service, 313 S. E. Second St., Evansville, Ind.

CASEWORK SUPERVISOR in voluntary, non-institutional, child-placing agency with emphasis on growing adoption program. Member CWLA. Liberal personnel practices and good salaries. Supervisory experience preferred, but not essential if training and experience are adequate. Kerth W. Hardy, Director, Children's Bureau, 615 N. Alabama St., Indianapolis 4, Ind.

CASEWORKER for voluntary, non-institutional, child-placing agency with emphasis on growing adoption program. Member CWLA. Liberal personnel practices, good salary schedule. Professional training required. Kerth W. Hardy, Director, Children's Bureau, 615 N. Alabama St., Indianapolis 4, Ind.